Methods and Standards for Establishing Payment Rates -- Other Types of Care

I. Drugs

A. Reimbursement Method

Participating pharmacies are reimbursed for the cost of the drug as defined by the Program plus a dispensing fee. This represents the payment in full for covered services provided in accordance with the Medical Assistance Outpatient Drug Program policies and procedures, and such payment shall not exceed the upper limits specified in 42 CFR 447.331 through 447.334.

Participating dispensing physicians who practice in counties where no pharmacies are located are reimbursed for the cost of the drug only, with the cost computed as the maximum allowable cost, the estimated acquisition cost, or the physician's customary and usual charge to the general public for the drug if less.

B. Determination of Drug Costs

1. The upper limit for payment for prescribed drugs shall be based on the lower of the cost of the drug (as determined in accordance with paragraphs (2) and (3) of this section) plus a dispensing fee established by the state, or the provider's usual and customary charge to the general public.

2. For each multiple source drug designated by the program, cost will be limited to the lower of:

   (a) The Federal Maximum Allowable Cost (FMAC) established for such drug, or

   (b) The Estimated Acquisition Cost (EAC) as defined in paragraph (3) of this section.

3. For all prescribed drugs, cost shall not exceed an upper limit established by the program; this shall be the program's closest estimate of the price generally and currently paid by providers.

The estimated acquisition cost for drugs shall not exceed the average wholesale price (AWP) minus ten (10) percent; if an AWP is not listed, the EAC shall be the direct price.

4. The federal maximum allowable cost refers to multiple source drug upper limits established by the Health Care Financing Administration (HCFA). These upper limits represent 150 percent of the lowest average wholesale price (AWP) listed in national pricing publications. Drugs included in the HCFA list must have at least three suppliers and be considered interchangeable by the Food and Drug Administration.

5. The maximum allowable cost price limitation will not apply in any case in which a physician certifies that in his medical judgement a specific covered brand is medically necessary for a particular patient. In such cases, reimbursement is based on the lower of the EAC plus a professional dispensing fee or the provider's usual and customary charge to the public for the drug.

C. Professional (Dispensing) Fee

The professional fee is intended to reimburse the participating pharmacy for the services of judgement and surveillance provided by the pharmacist, that is, dispensing the proper drugs in appropriate containers with appropriate labeling, including administration directions, storage instructions, labeling and filing information, and appropriate counseling with patients regarding the prescription, and notification of prescribing physician regarding possible drug interactions. The dispensing fee is set at $4.75 per prescription (or refill, as applicable) for all prescriptions except those for nursing facility residents meeting patient status criteria; the dispensing fee for nursing facility residents meeting patient status criteria is set at $5.75 per prescription (or refill, as applicable). The following additional dispensing fee provisions are also applicable.

1. For nursing facility residents meeting Medicaid patient status criteria, there shall be no more than one (1) dispensing fee allowed per drug within a calendar month for maintenance drugs (as determined by the Medicaid agency) and no more than two (2) dispensing fees allowed per drug within a calendar month for other drugs, except for Schedules II, III, and IV controlled substances and for non-solid dosage forms, including topical medication preparations, for which no more than four (4) dispensing fees per drug shall be paid within a calendar month. For nursing facility residents not meeting Medicaid patient status criteria and non-residents of nursing facilities, there shall be no more than one (1) dispensing fee allowed per drug per calendar month for drugs classified by the Medicaid program as maintenance drugs and no more than four (4) dispensing fees shall be allowed per drug within a calendar month for legend intravenous drugs. (Though dispensing fees are limited, this shall not be construed as placing a limit on the quantity of reimbursable drugs for which the program will pay for any patient, since the reasonable cost of the drug (as defined herein) is reimbursable as a covered service in whatever quantity is considered medically necessary for the patient. Non-solid dosage forms include all covered drug items other than oral tablets or capsule forms.)

2. For nursing facility residents meeting Medicaid patient status criteria, an addition to the usual dispensing fee of five (5) dollars and seventy-five (75) cents shall be made for drugs dispensed through the pharmacy outpatient drug program in the amount of two (2) cents per unit dose for unit dose drugs packaged in unit dose form by the manufacturer and four (4) cents per unit dose for unit dose drugs packaged in unit dose form by the pharmacist.

D. Reevaluation of Professional Fee

The professional (dispensing) fee is reevaluated by the program at intervals. To assist in the reevaluation, the state shall periodically conduct surveys of costs of pharmacy operation, including such components as overhead, professional services, and profits.

E. Drugs for Inpatients Receiving Nursing Facility Care

Drugs provided to inpatients in nursing facilities will be paid for in accordance with the reimbursement provisions contained herein except that reimbursement for drugs provided to patients in nursing facility brain injury units and nursing facility ventilator dependent units shall be as a part of the all inclusive rate for the unit and the payments for such drugs shall be in accordance with the MAC/EAC upper limits.

II. Physician Services

A. Definitions.

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medial Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

B. Reimbursement

(1) Payment for covered physicians' services shall be based on the physicians' usual and customary actual billed charges up to the fixed upper limit per procedure established by the Department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

(2) RBRVS units shall be multiplied by a dollar conversion factor to arrive at the fixed upper limit. The dollar conversion factors shall be as follows:

Types of Service	Kentucky Conversion Factor
Deliveries	Not applicable
Anesthesia (except delivery-related)	$29.02
All Other Services	$29.67

C. Reimbursement Exceptions.

(1) Except as otherwise specified herein, physicians will be allowed to secure drugs for specified immunizations free from the Department for Public Health to provide immunizations for Medicaid recipients, with reimbursement for the cost of the drugs made from the Department for Medicaid Services to the Department for Public Health upon receipt of notice from the physicians that the drugs were used to provide immunizations to Medicaid recipients.

(2) Except as otherwise specified herein, physicians will be allowed to purchase drugs for specified immunizations in the open market to provide immunizations for Medicaid recipients and the Department for Medicaid Services will reimburse the physician the same amounts that would have been paid to the Department for Public Health if the drugs had been obtained through that agency upon receipt of appropriate notice that the drugs were used to provide immunizations to Medicaid recipients.

(3) Effective October 1, 1994, physicians shall be provided drugs for specified immunizations through the pediatric vaccine distribution program to be administered by the Department for Public Health in accordance with the terms, standards, and criteria described in 42 USC 1396a(a)(62) and 1396s.

(4) Payments for obstetrical delivery services provided on or after September 15, 1995 shall be reimbursed the lesser of the actual billed charge actual billed charge or at the standard fixed fee paid by type of procedure. The obstetrical services and fixed fees are:

Vaginal delivery only	$870.00
Vaginal delivery including postpartum care	900.00
Cesarean delivery only	870.00
Cesarean delivery including postpartum care	900.00

(5) For delivery-related anesthesia services provided on or after July 1, 1995, a physician shall be reimbursed the lesser of the actual billed charge or a standard fixed fee paid by type of procedure. Those procedures and standard fixed fees are:

Vaginal delivery	$200
Epidural single	315
Epidural continuous	335
Cesarean section	320

(6) Payment for individuals eligible for coverage under Medicare Part B is made in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(7) For services provided on or after July 1, 1990, family practice physicians practicing in geographic areas with no more than one (1) primary care physician per 5,000 population, as reported by the United States Department of Health and Human Services, shall be reimbursed at the physicians' usual and customary actual billed charges up to 125 percent of the fixed upper limit per procedure established by the Department.

(8) For services provided on or after July 1, 1990, physician laboratory services shall be reimbursed based on the Medicare allowable payments rates. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

(9) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the physician's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

(10) Payments for Injection Procedure for Chemonucleolysis of Intervertebral disk(s), lumbar shall be paid the lesser of the actual billed charge or at a fixed upper limit of $793.50 as established by the Department.

(11) Specified family planning procedures performed in the physician office setting shall be reimbursed at the lesser of the actual billed charge or the established RBRVS fee plus actual cost of the supply minus ten percent.

(12) Certain injectable antibiotics and antineoplastics, and contraceptives shall be reimbursed at the lesser of the actual billed charge or at the average wholesale price of the medication supply minus ten (10) percent.

(13) When oral surgeons render services which are within the scope of their licensed oral surgery practice, they shall be reimbursed as physicians (i.e., in the manner described above).

(14) Any physician participating in the lock-in program will be paid a $10.00 per month lock-in fee for provision of patient management services for each recipient locked-in to that physician.

D. Assurances. The state hereby assures that (1) payment for physician services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

III. Dental Services

A. Definitions.

For the purpose of determination of payment, usual and customary actual billed charge refers to the uniform amount the individual dentist charges in the majority of cases for a specific dental procedure or service.

B. Reimbursement for Outpatient and Inpatient Services.

(1) Except as specified under Reimbursement Exceptions, the Cabinet shall reimburse a participating dentist for a covered service provided to an eligible Medicaid recipient at the dentist's usual and customary actual billed charge up to the fixed upper limit per procedure established by the Cabinet at 78 percent of the median billed charge using 1993 calendar year billed charges.

(2) If there is no median available for a procedure or the Cabinet determines that available data relating to the median for a procedure is unreliable, the Cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of fixed upper limits for the type of service. "General array of upper limits" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the upper limits for procedures which are similar in nature. The listing of similar services is referred to as the "general array". The actual upper limit is derived by using not less than 3 other sources such as Worker's Compensation, other federal programs, other state or local governments, and health insurance organizations. If a rate is not available from these sources, rates are then solicited from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are averaged, then compared to similar procedures paid in comparable circumstances by the Medicaid program. After the average rate is determined, the appropriate percentage of billed charges (found in III. B. (1)) would be applied to establish the fixed upper limit.

(3) Fixed upper limits not determined in accordance with the principles shown in this section, due to consideration of other factors (such as recipient access), shall be specified under Reimbursement Exceptions.

C. Hospital Inpatient Care

(1) Hospitalized inpatient care refers to those services provided to an inpatient. It does not include dental services provided in the outpatient extended care or home health unit of a hospital. Any dentist submitting a claim for hospital inpatient care benefits must agree to accept payment in full for services provided to that patient during the admission.

(2) A general dentist may submit a claim for a hospital inpatient service for the patient termed "medically high risk." Medically high risk is defined as a patient in one(1) of the following classifications:

(a) Heart disease;
(b) Respiratory disease;

(c) Chronic bleeder;
(d) Uncontrollable patient i.e. a person with mental or emotional disorder; or
(e) Other, e.g. car accident, high temperature, massive infection, etc.

D. Reimbursement Exceptions

(1) All comprehensive orthodontic procedures shall require prior authorization. The following comprehensive orthodontic procedures shall pay at a fixed fee:

Orthodontic Consultation, $84.70, except that the fixed fee is $42.35 if the provider is referring the recipient to a specialist or the prior authorization for orthodontic services is not approved or a request for prior authorization of orthodontic services is not made;

Early phase for moderately severe or severe disabling malocclusion, $1,030 for an orthodontist and $930 for a general dentist;

Services for moderately severe disabling malocclusions, $1,375 for an orthodontist and $1,250 for a general dentist;

Services for severe disabling malocclusions, $2,075 for an orthodontist and $1,850 for a general dentist.

(2) The upper limit for the following procedures shall be the fixed upper limit derived utilizing the methodology described in Reimbursement for Outpatient and Inpatient Services increased by the following percentages:

Procedures	% of Increase
Initial Oral Exam	25%
Prophylaxis	20%
Amalgam	10%
Resin	7%
Prefabricated Stainless Steel Crown	5%
Prefabricated Resin Crown	5%
Pin Retention	10%
Pulp Cap (Direct)	10%
Pulpotomy (Therapeutic)	10%
Root Canal	10%
Simple Extraction	5%

(3) This reimbursement methodology does not apply to an oral surgeon's services which are included within the scope of his oral surgery license. Those services are reimbursed as a physician's service rather than as a dentist's service.

(4) Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. The state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization for services beyond the stated limitations or not covered under the Title XIX state plan.

Preauthorized early phase orthodontic services for moderately severe or severe handicapping malocclusion, $1,200 for orthodontists and $1,080 for general dentists;

Preauthorized orthodontic services for moderately severe handicapping malocclusions, $1,600 for orthodontists and $1,440 for general dentists;

Preauthorized orthodontic services for severe handicapping malocclusions, $2,400 for orthodontists and $2,160 for general dentists;

(3) This reimbursement methodology does not apply to oral surgeons' services which are included within the scope of their oral surgery licenses. Those services are reimbursed as physicians' services rather than dentists' services.

(4) Kentucky will comply with the requirements in Section 1905 of the Social Security Act relating to medically necessary services to EPSDT recipients. For services beyond the stated limitations or not covered under the Title XIX state plan, the state will determine the medical necessity for the EPSDT services on a case by case basis through prior authorization.

IV. Vision Care Services

A. Definitions

For purposes of determination of payment, "usual and customary actual billed charge" refers to the uniform amount which the individual optometrist or ophthalmic dispenser charges in the majority of cases for a specific procedure or service.

B. Reimbursement for Covered Procedures and Materials for Optometrists.

(1) Reimbursement for covered services, within the optometrist's scope of licensure, except materials and laboratory services, shall be based on the optometrists' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) on parity with medical doctors as described in item 2, below. Fixed upper limits not determined in accordance with the RBRVS methodology (due to factors such as availability) shall be set by the Cabinet using the following methodology.

The fixed upper limit for the procedure shall be consistent with the general array of rates for the type of service. "General array of fixed rates" means that the rate upper limit set for the procedure will be at the same relative level, so far as possible, as the rates for procedures which are similar in nature. The listing of similar services is referred to as the "general array". The actual upper limit is derived by using not less than 3 other sources such as Medicare, Workman's Compensation, other federal programs, other state or local governments, and health insurance organizations or if a rate is not available from these sources then we solicit rates from at least 3 of the highest volume instate providers of the services. After obtaining at least 3 rates, the rates are added together then divided by the number of rates to obtain an average rate which is then compared to similar procedures paid in comparable circumstances by the Medicaid program to set the upper limit.

(2) RBRVS units used shall be the same as those used in the physicians services program, with the units multiplied by the "all other services" conversion factor to arrive at the fixed upper limits for each procedure.

(3) Reimbursement for materials (eyeglasses or parts of eyeglasses) shall be made at the optical laboratory cost of the materials not to exceed upper limits for materials as set by the cabinet. An optical laboratory invoice, or proof of actual acquisition cost of materials, shall be maintained in the recipient's medical records for post-payment review. The agency upper limits for materials are set based on the agency's best estimate of reasonable and economical rates at which the materials are widely and consistently available, taking into consideration statewide billing practices, amounts paid by Medicaid programs in selected comparable states, and consultation with the optometric Technical Advisory Committee of the Medical Assistance Advisory Council as to the reasonableness of the proposed upper limits.

(4) Laboratory services shall be reimbursed at the actual billed amount not to exceed Medicare allowable payment rates; if there is no established Medicare allowable payment rate, the payment shall be sixty-five (65) percent of usual and customary actual billed charges.